

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021155

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 150

FILED MAY 24 1963

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		c. CITY OR TOWN St. Charles	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If outside, give location) 1008 Chargene	
3. NAME OF DECEASED (Type or print) First Middle Last Barbara A. Carlson		4. DATE OF DEATH Month Day Year 5 16 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-1-40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		11. BIRTHPLACE (City and state or country) Marcus, Iowa	
13a. FATHER'S NAME John Coburn		14. NAME OF HUSBAND OR WIFE James Carlson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		17. INFORMANT Address James Carlson St. Charles, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized carcinomatous primary colon</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>2/1/63</i> to <i>5/16/63</i> and last saw her alive on <i>5/15/63</i> . Death occurred at <i>8:20 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Paul W. Schell III, M.D.</i>		22b. ADDRESS <i>51 Charles Chinn</i>	
22c. DATE SIGNED <i>5/16/63</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-16-63	23c. NAME OF CEMETERY OR CREMATORY Marcus Cemetery	23d. LOCATION (City, town, or county) Marcus Iowa
24. FUNERAL DIRECTOR Arthur C. Baue	25. DATE RECD. BY LOCAL REG. 5/16/63	26. REGISTRAR'S SIGNATURE <i>Mary E. Jackson, Act. Reg.</i>	

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

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JUN 5 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Connie L. Pickering

Licensed Embalmer No. 5189

P. O. Address St. Charles, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.